

Centennial Care 1115 Waiver Renewal Subcommittee Care Coordination Brief October 14, 2016

Background

Launched on January 1, 2014, Centennial Care provides a comprehensive delivery system for Medicaid members that integrates physical, behavioral and long-term care services; ensures cost-effective care; and focuses on quality over quantity.

Fundamental to the program is a robust care coordination system that requires coordination at a level appropriate to each member's needs and risk stratification. The care coordination program creates a person-centered environment in which members receive the care they need in the most efficient and appropriate manner. Care coordination activities include:

- Assessing each member's physical, behavioral, functional and psychosocial needs;
- Identifying the medical, behavioral and long-term care services and other social support services and assistance, such as housing and transportation;
- Ensuring timely access, coordination and monitoring of services needed to help each member maintain or improve his or her physical and/or behavioral health status or functional abilities while maximizing independence; and
- Facilitating access to other social support services and resource assistance needed in order to promote each member's health, safety and welfare.

All Medicaid members receive a health risk assessment (HRA) and are placed in an appropriate level of care coordination 2 or 3. Those in higher levels of care coordination (level 2 or 3) receive a comprehensive needs assessment (CNA) to assess physical, behavioral and long-term care (LTC) needs and receive a person-centered care plan. Members in care coordination level 2 receive semi-annual in-person visits, quarterly telephone contact, and an annual CNA to determine if the level of coordination and care plan are appropriate. Members in care coordination level 3 receive monthly telephone contact, quarterly in-person visits and a semi-annual CNA to determine if the level of coordination and care plan are appropriate.

The following outlines the requirements for care coordination level 2 and 3:

Based on the CNA, care coordination **level 2** will be assigned to a member with **one** of the following:

- Co-morbid health conditions;
- High emergency room used, defined as 3 or more emergency room visits in 30 days;
- A mental health or substance abuse condition causing moderate functional impairment;
- Requiring assistance with 2 or more Activities of Daily Living (ADL) or Instrumental Activities of Daily Living(IADL) living in the community at low risk;
- Mild cognitive deficits requiring prompting or cues; and/or
- Poly-pharmaceutical use, defined as simultaneous use of 6 or more medications from different drug classes and/or simultaneous use of 3 or more medications from the same drug class.

Based on the CNA, care coordination **level 3** will be assigned to a member with **one** of the following:

- Who are medically complex or fragile;
- Excessive emergency room use as defined as 4 or more emergency room visits in a 12 month period;
- A mental health or substance abuse condition causing high functional impairment;
- Untreated substance dependency based on the current DSM or other functional scale determined by the State;
- Requiring assistance with 2 or more ADLs or IADLs living in the community at medium to high risk;
- Significant cognitive deficits; and/or
- Contraindicated pharmaceutical use.

The following outlines the caseload to care coordination ratios:

<p>Care coordination level 2:</p> <ul style="list-style-type: none"> • Members not residing in a nursing facility 1:75, and • Members residing in a nursing facility 1:125; and • Members age twenty-one (21) and over who participate in the Self-Directed Community Benefit 1:100;
<p>Care coordination level 3:</p> <ul style="list-style-type: none"> • Members not residing in a nursing facility 1:50; and • Members residing in a nursing facility 1:125; and • Members age twenty-one (21) and over who participate in the Self-Directed Community Benefit in care coordination 1:75; and
<p>Care coordination for Members who participate in the Self-Directed Community Benefit:</p> <ul style="list-style-type: none"> • Members under age of twenty-one (21) 1:40

Care Coordination Monitoring

The State conducts a variety of activities to monitor the MCOs' care coordination activities. In 2014 and 2015, the State conducted 1 onsite audit and 2 desk audits of MCO Care Coordination member records. The desk audits have shown:

- Improvement in MCO compliance with Care Coordination contractual requirements
- A need for further development of the MCO care coordinators, including improving member engagement rates and
- A need for improved documentation of member needs.

As a result, the MCOs developed internal action plans to address concerns or deficits found in the audits. Action plans include more information about the MCOs' self-auditing, trend identification, and details related to following-up on expected outcomes. The State conducts ongoing monitoring of the MCOs' internal action plans, provides ongoing technical assistance, and conducts trainings for MCO Care Coordinators on general Care Coordination activities and Care Coordination documentation requirements.

Each year, Medicaid Centennial Care members participate in the Consumer Assessment of Healthcare Provider and Systems (CAHPS) survey. In relation to Care Coordination, the survey reported an average of 78% member satisfaction for the 2014 survey. The 2015 survey is due in October 2016. In

addition, the MCOs are required to submit quarterly reports to the State regarding care coordination activities including the number of HRAs, CNAs and Comprehensive Care Plans (CCPs) completed.

Accomplishments Related to Care Coordination

The Centennial Care MCOs have hired approximately 950 care coordinators. The MCOs have conducted 610,000 health risk assessments and have assigned 70,000 members to higher levels of care coordination (levels 2 and 3). These assessments have resulted in more than 250,000 members receiving care in patient-centered medical homes and more than 24,000 members receiving home and community based services. The MCOs have collaborated with the University of New Mexico's ECHO Care program to provide access to an intensivist team for 500 high need/high cost members that included primary care physicians, behavioral health counselors, specialists as needed, and community health workers.

During the period of September 2014 through June 2016, the MCOs launched a campaign to reach those members who were unreachable. Successful strategies included but were not limited to:

- Call campaigns were implemented;
- Contracts with several organization were established to complete HRAs;
- Member advocates were deployed to residential addresses to make in-person visits;
- Specialized care coordination teams were developed to locate members; and
- Offices were set-up specifically for walk-in members who need assistance.

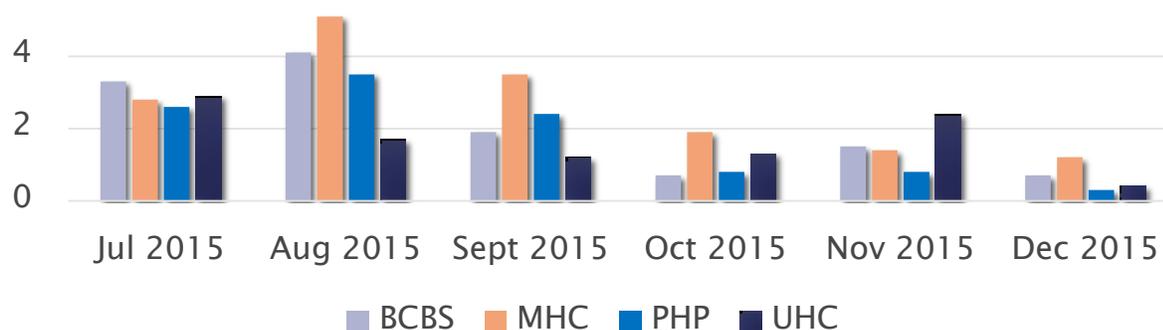
As a result, 248,513 previously unreachable members were successfully reached by the MCOs during this campaign. The percent of unreachable members, as compared to enrollment, decreased to 11.62% and 164,267 HRAs were completed during this period.

In order to develop a solid Care Coordination infrastructure, the State and the MCOs recognized the importance of Community Health Workers (CHWs) in assisting with the engagement of members in their healthcare. CHWs also provide health education, health literacy, and community support linkage. The State included a Delivery System Performance Improvement Target within the MCOs' contracts to increase the utilization of CHWs. To date, the MCOs have:

- Employed more than 100 CHWs directly or through a contractual relationship;
- Utilized CHWs to work with members who are high Emergency Department (ED) utilizers and redirect them to PCPs; and
- Partnered with UNM to expand the role of CHWs

In addition to the use of CHWs in working with members who have high ED utilization, the State implemented the Super Utilizer Project with MCOs to track members with ED use. The goal of the project is to review MCO care coordinator activities with the selected members in an effort to reduce this utilization, as well as share successful activities resulting in reduced utilization with all MCOs. The MCOs have identified that intensive engagement with some members and addressing their medical deficits (i.e., inability to fill medications) their ED utilization decreases. It is important to note

that some members take longer to accept the engagement and some will ultimately refuse. The following graph illustrates progress in ED reduction for the top 10 utilizers with each MCO.



The State provided the MCOs with access to the Predictive Risk Intelligence System (PRISM) to assist with monitoring member utilization. PRISM provides the MCOs with historical member service utilization. The MCOs have collaborated to begin utilization of the Emergency Department Information Exchange (EDIE), to enhance Care Coordination Activity at Emergency Departments. EDIE will provide the MCOs with real time data regarding member utilization of the ED. HSD had defined varying levels of ED utilization (excessive, frequent, and high) for the MCOs to better define the need for care coordination for members.

In 2015, in an effort to streamline care coordination processes, the State and the MCOs collaborated to streamline the Health Risk Assessment (HRA) across all four MCOs. Streamlining of the HRA provided uniformity for MCOs in identifying Medicaid members who need a CNA and potentially a higher level of care coordination.

In 2016, the State and MCOs implemented the Health Home project for members with Severe Mental Illness (SMI) or Severe Emotional Disturbance (SED) in 2 counties (Curry and San Juan) to enhance the integration and coordination of primary, acute, behavioral health and long-term care services. This phase I implementation allows for the delegation of care coordination to the selected provider agencies and allows HSD to monitor impact for potential expansion statewide.

Additional MCO care coordination initiatives include:

- Molina Healthcare working with the Metropolitan Detention Center (MDC) to begin Care Coordination prior to an incarcerated member's release.
- MCOs partnering with community agencies, such as Albuquerque Ambulance and Kitchen Angels, to conduct home visits for super ED utilizers.

Care Coordination Challenges

As Centennial Care continues to grow, there continues to be room for improvement and opportunities to enhance the program through furthering best practices identified. Engaging certain members in the care coordination process continues to be a challenge, particularly those who are classified as "high

utilizers”. Communication between care coordinators and various partners (hospitals, nursing homes) needs to be strengthened and incentivized. Thoughtful role definition and collaboration between MCO care coordinators and Department of Health case managers for the Developmentally Disabled and Medically Fragile populations requires continuous review. Finally, HSD continues to work towards further enhancing the seamless integration of physical and behavioral health services.

New Ideas for Care Coordination

HSD has reviewed information from a variety of data sources including claims and utilization trends, HEDIS outcomes, MCO reports, Special Project reports and Care Coordination reviews and file audits. In addition, HSD continually looks to other states for models with positive outcomes. Great strides have been made in the implementation of a comprehensive care coordination model, the training and capacity building of MCO staff and initial outcomes from the investment in care coordinators.

HSD has identified a few areas where an enhancement or shift in the approach to Care Coordination promises to continue to improve health outcomes, lower cost and increase member participation in managing their own care.

While these are not the only ideas HSD is considering, the following are Care Coordination priorities for discussion with this sub-committee as we continue the process of refining our vision:

- Focus on Transitions of Care through targeted care coordination.
- Increase care coordination and competency to manage the unique challenges of special populations such as high utilizers, inmate populations, and members who are difficult to engage in care coordination.
- Increase access to care coordination functions at the provider level when appropriate
- Implement a Coordination First Model - allows for multiple care coordination contacts to complete assessments
- Expansion of the Health Home pilot to allow selected providers to conduct care coordination activities